STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152572	A. BUILDING _____ B. WING _____	C 10/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DSI GREENWOOD RENAL CENTER	**125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS This was a federal ESRD complaint investigation. Complaint IN00148442 - Unsubstantiated: Lack of sufficient evidence. Survey dates: 10/14/14 and 10/15/14. Facility Number: 002935 Medicaid Number: 20082725 Surveyor: Michelle Weiss RN MSN Public Health Nurse Surveyor Census: 63 InCenter Hemodialysis Patients 4 Home PD Patients DSI Greenwood Renal Center is in compliance with Conditions for Coverage 42 CFR 494.60, 494.70, and 494.170 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN October 21, 2014	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE